Table of Contents

Administrative Functions

Dental Credentialing

Re-credentialing

Dental Provider Networks
- Participating Provider Network (PAR)
- Preferred Provider Network (PPO)
- Dental GRID+ and Dental GRID
- Federal Employee Program (FEP) Preferred Dental Network
- Dental HMO (DHMO)

Provider Agreements
- Participating Agreement, Preferred Addendum, Federal Employee Program Amendment
- DHMO Participating Agreements
- Administrative Services Policy
- Changes in Provider Information
- Availability (DHMO)
- Specialty Referral Criteria (DHMO)
- Primary General Dentist Responsibilities (DHMO)
- Specialist Responsibilities (DHMO)

Provider Reimbursement
- Notice of Payment (NOP)
- Electronic Capabilities
- Capitation (DHMO)
- Retroactive Capitation (DHMO)
- Member Copayments (DHMO)
- Get Fees
- Reimbursement Methodology

Indemnity Other Party Liability (OPL)

Coordination of Benefits
- Primary Carrier: CareFirst Traditional and Preferred Dental Products

This manual provides information for CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., and The Dental Network (collectively CareFirst) Dental providers.

Per the terms of the Participating Agreement, all providers are required to adhere to all policies and procedures contained in this manual, as applicable. If we make any administrative or procedural changes, we will update the information in this manual and notify you through email and BlueImpressions, our online Dental provider newsletter.

Specific requirements of a member’s Dental benefits vary and may differ from the general procedures outlined in this manual. If you have questions regarding a member’s eligibility, benefits, or claims status information, we encourage you to use one of our self-service channels CareFirst Direct or CareFirst on Call. Through these channels, simple questions can be answered quickly.
Table of Contents

Secondary Carrier: CareFirst Traditional or Preferred Dental Products
COB Provision
Workers’ Compensation
Subrogation
Personal Injury Protection (PIP)
DHMO Coordination of Benefits (COB)
Primary General Dentist (PGD)
Specialist

Orthodontia
Primary Carrier ACA embedded Pediatric Dental

Dental Claims Submission

Submission Guidelines
- Timely Filing of Claims
- Claims Filing
- Dental Procedures and Nomenclature
- Completing a Claim Form
- Pre-Treatment Estimates (PTE)
- DHMO Claims
- Oral Surgery and Accidental Injury
- Dental Reference Guide for Required Attachments

ACA Pediatric Orthodontia
- Other Requirements
- Inquiries and Appeals
- Refunding Erroneous Payments

Dental Claims Processing Policies

Edits, Limitations and Billing Guidelines
- Mutually Exclusive Edits
- Rebundling Edits
- Incidental to/Included in/Integral part of

Common Limitations and Exclusions
- General Criteria
- Diagnostic/Preventive Services
- Restorative Services
- Endodontic Services
- Periodontal Services
- Oral Surgical Services

Anesthesia Services
Orthodontic Services
Initial Consultation
Diagnostic Records
Active Comprehensive Orthodontic Treatment
Benefit Guidelines for Traditional and Preferred Dental
Billing Guidelines for Individual Select Preferred (ISP)
Billing Guidelines for DHMO

Billing Guidelines for Patients with Dual Orthodontic Coverage
- Patient Qualifies for Dual Orthodontic Coverage
- Patient Does Not Qualify for Dual Orthodontic Coverage

Orthodontic Lifetime Maximum
- Orthodontic Treatment in Progress
- Members Transferring from Another Orthodontist

Traditional and Preferred Dental Guidelines for Dental Implants
- Clinical Guidelines
- Provider Guidelines
- Member Contractual Limitations and Exclusions for Standard Traditional and Preferred Dental Members

Financial Responsibility
- Implant Quality Assurance

Membership and Product Information

Membership
- Member’s Rights and Responsibilities

Identifying Product Type by Indicator

Membership Identification Card
Quick Reference Guide
## How to Identify the Product on the ID Card

<table>
<thead>
<tr>
<th>Product Description</th>
<th>Where to Send Claims</th>
<th>Where to Send Correspondence</th>
<th>Payor ID</th>
<th>What Provider Number to Use</th>
<th>What Number to Call</th>
</tr>
</thead>
</table>
| **Traditional Dental**
  Indicator: DT/GRID+ | Mail Administrator
  P.O. Box 14115
  Lexington, KY 40512-4115 | Mail Administrator
  P.O. Box 14114
  Lexington, KY 40512-4114 | Tax ID Number | 866-891-2804 |
| **Preferred Dental**
  Indicator: DP/GRID | | | Tax ID Number | 866-891-2804 |
| **Individual Select Preferred**
  Indicator: DS | Mail Administrator
  P.O. Box 14118
  Lexington, KY 40512-4118 | Mail Administrator
  P.O. Box 14118
  Lexington, KY 40512-4118 | 00580 | 410-847-9060 or 888-833-8464 |
| **Dental HMO (The Dental Network)**
  Indicator: DH | Mail Administrator
  P.O. Box 14118
  Lexington, KY 40512-4118 | Mail Administrator
  P.O. Box 14118
  Lexington, KY 40512-4118 | Tax ID Number | 410-847-9060 or 888-833-8464 |
| **Discount Dental**
  No indicator. Included with BlueChoice medical coverage. | | | | |
| **National Claims Administrative Services (NCAS)** | P.O. Box 981610
  El Paso, TX 79998 | P.O. Box 981610
  El Paso, TX 79998 | 75190 | Tax ID Number | 866-219-9292 |
| **CareFirst Administrators (CFA)** | P.O. Box 981610
  El Paso, TX 79998 | P.O. Box 981610
  El Paso, TX 79998 | 75191 | Tax ID Number | 866-945-9839 |
| **CareFirst Pediatric Dental**
  Indicator: PD | Mail Administrator
  P.O. Box 14115
  Lexington, KY 40512-4115 | Mail Administrator
  P.O. Box 14114
  Lexington, KY 40512-4114 | Tax ID Number | 866-891-2804 |
| **GRID and GRID+**
  Indicator: GRID (Dental Preferred)
  GRID+ (Dental Traditional) | Mail Claims to the Local BlueCross BlueShield Plan | Mail Correspondence to the Local BlueCross BlueShield Plan | Tax ID Number | Contact information should be on the back of the member's ID card. |

## FEP

| Providers in Montgomery & Prince George's counties, Washington, D.C., and Northern Virginia (east of Rt. 123)
  Prefix: “R” | Mail Administrator
  P.O. Box 14113
  Lexington, KY 40512-4113 | Mail Administrator
  P.O. Box 14112
  Lexington, KY 40512-4112 | Tax ID Number | 202-688-4900 |
| All other professional MD FEP providers
  Prefix: “R” | Mail Administrator
  P.O. Box 14113
  Lexington, KY 40512-4113 | Mail Administrator
  P.O. Box 14111
  Lexington, KY 40512-4111 | 00580 | Tax ID Number | 410-581-3568 or 800-854-5256 |
| **FEP BlueDental (Supplementary dental plan)**
  Indicator: FEP BlueDental Logo | FEP BlueDental Claims
  P.O. Box 75
  Minneapolis, MN 55440-0075 | FEP BlueDental Claims
  P.O. Box 75
  Minneapolis, MN 55440-0075 | Tax ID Number | 855-504-2583 |

## Dental Provider Networks

<table>
<thead>
<tr>
<th>Dental Provider Networks and Credentialing</th>
<th>Contact Information</th>
<th>Correspondence</th>
</tr>
</thead>
</table>
| | Telephone: 443-921-0676
Fax: 410-720-5080
dentalcontracting@carefirst.com | CareFirst BlueCross BlueShield Dental Contracting
10455 Mill Run Circle, Mailstop RRS-130
Owings Mills, MD 21117 |

## Self Service Options

| CareFirst Direct | Eligibility, Benefits, & Claim Status for Indemnity Dental. (Only eligibility and claim status available for FEP Dental.) | www.carefirst.com/providerlogin |
| CareFirst On Call | Eligibility, Benefits, & Claim Status (Only eligibility and claim status available) via telephonic interactive voice response. | CareFirst On Call Reference Dental Reference Card |
| SecureTrack Dental (formerly AnsLink) | Eligibility verification for DHMO. | www.secure-xchange.com |
Administrative Functions

This manual provides information for CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., and The Dental Network (collectively CareFirst) Dental providers.

Per the terms of the Participating Agreement, all providers are required to adhere to all policies and procedures contained in this manual, as applicable. If we make any administrative or procedural changes, we will update the information in this manual and notify you through email and BlueImpressions, our online Dental provider newsletter.

Specific requirements of a member’s Dental benefits vary and may differ from the general procedures outlined in this manual. If you have questions regarding a member’s eligibility, benefits, or claims status information, we encourage you to use one of our self-service channels CareFirst Direct or CareFirst on Call. Through these channels, simple questions can be answered quickly.

Dental Credentialing

Providers who want to participate in the CareFirst provider networks are required to submit credentialing information. This information is verified to confirm that our credentialing criteria are met. This includes but is not limited to:

- Valid, current, unrestricted licensure
- Valid, current Drug Enforcement Agency (DEA) and Controlled Dangerous Substance (CDS) registration, if applicable
- ECFMG certificate, if applicable
- Specialty board certification, if applicable
- Review of work history
- Acceptable history of professional liability claims
- Professional liability coverage certification which must include the limits of coverage of $1M/$3M, the expiration date and the name of the provider covered under the policy; shared limits coverage is not acceptable

To make sure that CareFirst has obtained correct information to support credentialing applications and made fair credentialing decisions, providers have the right, upon request, to review this information to correct inaccurate information and to obtain the status of the credentialing process. Requests can be made by calling 443-921-0676.

CareFirst accepts the Dental Provider Application and Council for Affordable Quality Healthcare (CAQH) Universal Credentialing Datasource application. With an updated online interface, new practitioners who complete their application online through the CAQH website will now receive notification from CAQH, with your CAQH ID, to access the website and complete the credentialing application online. When your application is complete, you have authorized CareFirst...
to access your data and the application data has been sent to CareFirst for processing.

The CAQH credentialing system compiles and organizes comprehensive data from more than 600,000 providers in 23 health plans nationwide at no cost to providers. As a result, providers avoid redundant submission of credentialing information to participating health plans and health care organizations. Only one completed application per provider is needed.

To start, download and print the **CAQH Dental Provider Data Sheet** application. Complete the form and fax it back to CareFirst Dental Provider Networks and Credentialing at 410-720-5080. CareFirst will fax your CAQH ID number that allows access to the online application. Be sure to authorize CareFirst to access your information and fax CAQH your supporting documents and attestation. CAQH will fax or email you notification that your application is complete and has been forwarded to CareFirst. CareFirst will then begin the credentialing process.

If you have already completed the application through another CAQH member insurance company:

- Be sure that you have verified your data within the last ninety (90) days.
- Authorize CareFirst to access your information via the **CAQH Credentialing Web site**.
- Complete the top portion of the **CAQH Dental Provider Data Sheet** and indicate that you have completed the CAQH application.
- Fax the CAQH Dental provider Data Sheet or **Dental practice questionnaire** and a complete **Dental Billing Authorization Form** indicating the networks you are interested in joining to 410-720-5080.

For more information on our credentialing process, go to [www.carefirst.com/dentalcredentialing](http://www.carefirst.com/dentalcredentialing).

All providers in a participating practice must be credentialled through the CareFirst credentialing process. Claims submitted for providers that are not credentialled will be returned.

**Re-credentialing**

All contracted dental providers are re-credentialled using the same criteria and standards that were required during the initial application process. Providers are re-credentialled by Verifpoint, a primary source verification vendor, on a two year cycle so that every provider is not re-credentialled at the same time.

CareFirst and Verifpoint participate with the CAQH Universal Provider Datasource (UPD) to streamline the re-credentialing process. By using the UPD, you provide your documentation once and then routinely review and attest to your data.

When you are scheduled for re-credentialing, you will receive notification from Verifpoint suggesting you complete the CAQH application. Note: Providers are not required to use CAQH to provide re-credentialing documentation. You may still submit hardcopies of the required documents to Verifpoint directly.

If you receive a letter from Verifpoint and have questions regarding the re-credentialing process, please contact Verifpoint directly at 888-273-3368.

**Dental Provider Networks**

To avoid confusion and unexpected out-of-pocket expenses for members, all providers in the same practice must participate in the same provider networks.

**Participating Provider Network (PAR)**

The Participating Provider Network provides a benefit for covered services based on the CareFirst Traditional Allowed Benefit. This level of reimbursement applies to members covered under the Traditional Dental Product.
Preferred Provider Network (PPO)
The Preferred Provider Network provides a benefit for covered services based on the CareFirst Preferred Allowed Benefit. This level of reimbursement applies to members covered under the Preferred Dental Product known as PPO.

Dental GRID+ and Dental GRID
The Dental GRID links dental provider networks, including the CareFirst Dental Provider Network and many of the nation’s Blue plans. Participating CareFirst dental providers are considered in-network for patients who are members of many Blue Cross and Blue Shield plans, and providers should check the patient’s member identification card for the GRID or GRID+ indicator before considering the plan to be in network. Providers file claims directly to the Blue Cross and/or Blue Shield plan where the member’s group benefits are located. Reimbursement is made to the participating provider, based on the current CareFirst provider agreement.

The Blue Cross and Blue Shield Association has partnered with the GRID Dental Corporation to administer FEP BlueDental. FEP BlueDental members will be able to utilize the GRID+ network as an in-network provider source. Read the FEP BlueDental Office Implementation Guide if you have questions or for more information, you are able to access a complete breakdown of the FEP BlueDental benefits here.

Federal Employee Program (FEP) Preferred Dental Network
The FEP Preferred Dental Network provides a benefit for covered services based on the FEP Maximum Allowable Charge (MAC). This level of reimbursement applies to members covered under the FEP Standard and Basic Dental products.

Dental HMO (DHMO)
The DHMO participating provider network includes a general dentist and specialist network. Members covered under the DHMO must select a general dentist and have dental care coordinated through their selected participating DHMO provider. When the clinical examination and evaluation reveals that the member requires treatment from a specialist, the general dentist must provide a written referral to an in-network specialist.

Provider Agreements
Participating Agreement, Preferred Addendum, Federal Employee Program Amendment
Licensed, eligible dental providers accepted in one of our dental networks will agree to provisions as stated in the Provider Agreement, the Preferred (PPO) Addendum, and/or the Federal Employee Program (FEP) Amendment including, but not limited to:
- Participating providers who practice with multiple provider groups, or have more than one office location and use the same tax identification number, must maintain the same level of network participation in each group and/or location.
- The participating provider agrees to file claims for services rendered to our members.
- The participating provider agrees to accept our Allowed Benefit/Preferred Allowed Benefit/MAC as payment in full for covered services.

DHMO Participating Agreements
General Dentists and Specialists accepted into the DHMO agree to the provisions stated in the Participating Agreement, including but not limited to:
- The participating dentist agrees to offer appointments to members so that there will be no unreasonable waiting period for appointments.
- The participating dentist agrees to accept the member copay as indicated on the Member Copayment Schedule.
- The participating dentist agrees to refer all members requiring the services of a dental specialist to a participating specialist in the network.

Administrative Services Policy
To help you evaluate your office’s current practices, our Administrative Services policy is provided below. In short, providers cannot require the payment of
charges above and beyond coinsurance, copayments and deductibles.

Participating providers shall not charge, collect from, seek remuneration or reimbursement from or have recourse against subscribers or members for covered services, including those that are inherent in the delivery of covered services. The practice of charging for office administration and expense is not in accordance with the Participating Dentist Agreement and Dental Provider Manual. Such charges for administrative services would include, by way of example, annual or per visit fees to offset the increase of office administrative duties and/or overhead expenses, malpractice coverage increases, writing prescriptions, copying and faxing, lab fees, completing referral forms or other expenses related to the overall management of patients and compliance with government laws and regulations, required of health care providers.

The provider may look to the subscriber or member for payment of deductibles, copayments or coinsurance, or for providing specific health care services not covered under the member’s Health Benefit Plan as well as fees for some administrative services. Such fees for administrative services may include, by way of example, fees for completion of certain forms not connected with the providing of covered services, missed appointment fees, and charges for copies of medical records when the records are being processed for the subscriber or member directly. Fees or charges for administrative tasks, such as those enumerated above may not be assessed against all members in the form of an office administrative fee, but rather to only those members who utilize the administrative service.

Changes in Provider Information
Providers who need to change their file information may submit a Change in Dental Provider Information Form, found in the Resources section of www.carefirst.com/providerforms > Dental. Any change to a provider file must be received in writing. Requests for termination are made effective 90 days from the date of receipt of the written request. Providers are expected to continue to provide services for eligible members until the effective date of the termination.

Written notification should be mailed to:
CareFirst BlueCross BlueShield
Dental Provider Networks and Credentialing
Mailstop RRS-130
10455 Mill Run Circle
Owings Mills, MD 21117
Fax: 410-720-5080
Email: dentalcontracting@carefirst.com

Provider files remain active until we are notified of termination, retirement, loss of licensure or death.

Availability (DHMO)
If it is necessary for a Primary General Dentist (PGD) to be absent from the office for more than 10 days, it is required that the dentist contact us to obtain approval of providing acceptable coverage for our members. The dentist will be responsible for the cost of care rendered to their assigned members during his/her absence.

A PGD is required to have a system in place to accommodate emergency appointments and after hour emergencies. Emergency appointments should be granted within 24 hours during normal workdays for members assigned to the practice. If the assigned member is refused or unable to contact the dentist, covering dentist, or office staff member, and must be seen elsewhere, the PGD office will be held accountable for out-of-network fees up to $75.

Specialty Referral Criteria (DHMO)
To be considered for specialty care coverage, the following criteria must be met:

- The member must be eligible in the primary general dentist office when services are rendered.
- The referral must be made by the PGD to the appropriate participating specialist after examining the patient.
A participating network specialist must provide the treatment.

**Primary General Dentist Responsibilities (DHMO)**
- When the clinical examination reveals that a DHMO member has treatment needs that require a specialist, select a specialist from the Find a Provider specialist list located on [www.carefirst.com](http://www.carefirst.com). If a participating specialist is not available in the area, the PGD must contact the DHMO Provider Service Department to obtain authorization to refer to a non-participating specialist. An authorization will only be provided if the member does not have access to an appropriate participating specialist within a 50 mile radius.
- Verify that the procedure is a covered benefit according to the member’s plan. Non-covered procedures may be referred to a specialist; however, the member will be responsible for all fees incurred.
- A written referral with a preliminary clinical diagnosis and appropriate radiographs should be sent to the specialist. One copy of the referral form is retained by the referring dentist and two copies should be forwarded to the specialist.
- The PGD is responsible for instructing and preparing the member for the appointment with the specialist, including taking the referral and radiographs to the specialist.

**Specialist Responsibilities (DHMO)**
- Provide treatment for the member as indicated on the referral form.
- Collect applicable copayment and submit claim(s) to the address listed on the Dental Claims and Service Reference Guide.
- If the specialist has questions concerning the benefit coverage for a non-routine case or treatment, please contact the DHMO Provider Service Department.

---

**Provider Reimbursement**

**Notice of Payment (NOP)**
Participating providers are reimbursed by CareFirst for covered services rendered to CareFirst members. An NOP accompanies each check and enables providers to identify members and the claims processed for services rendered to those members. Participating providers are reimbursed according to the CareFirst Allowed Benefit as listed on the Dental Fee Schedules.

**Electronic Capabilities**

New electronic capabilities include:

- Electric Funds Transfer (EFT) – Allows providers to receive payments electronically. A clearinghouse manages provider enrollment and validation date.
- Electronic Remittance Advice (ERA) – Equivalent to the Notice of Payment. Some clearinghouses auto-post the ERA and EFT to the patient’s account using the providers Practice Management System. Our new paperless submission capabilities are designed to improve efficiency, reduce administrative complexity and improve turnaround time. Claims for FEP members can now also be submitted electronically.

Other features include:

- Dedicated dental Electronic Data Interchange (EDI) staff members
- Around-the-clock systems monitoring
- Reliable, flexible and secure systems that use state-of-the-art technology
- Electronic transactions for eligibility, benefit, and claim status requests

If you do not currently submit claims electronically, contact one of our preferred clearinghouses:

- Change Healthcare at (866) 369-8805
- Tesia Clearinghouse, LLC at (800) 724-7240

**Capitation (DHMO)**

Capitation is paid to participating general dentists for each member who has selected his/her office as their primary dental site. The Capitation Report is
Administrative Functions

mailed with the capitation check between the 15th and 20th of each month. Capitation rates for each plan are listed on each Member Copayment Schedule. Capitation is not paid on members age 2 or younger unless the capitation payment is being paid at a family level.

**Retroactive Capitation (DHMO)**

If a member selects your office after the effective date of coverage, retroactive capitation will be paid based upon the member's effective date. Retroactive capitation is not to exceed 90 days or three months capitation. Since all members must select a primary care dentist at the time of enrollment, it would be unusual for retroactive capitation to exceed one month. If a member terminates from your practice and capitation has been paid, the DHMO will be entitled to deduct the overpayment not to exceed 90 days or three months capitation. Treatment rendered to a member after the date of termination can be charged as fee-for-service.

**Member Copayments (DHMO)**

Member copayments are collected by the office at the time of service based on the copayment listed on the Member Copayment Schedule. Some procedures on the schedule list two copayment amounts. The amount on the left is due when the service is rendered by the primary care dentist. The amount on the right is due when the service is rendered by a specialist to whom the member was referred.

**Get Fees**

Your office can now obtain fee schedule and reimbursement agreements on CareFirst Direct. This may require updating your permissions, which can be done by following the instructions on this document. When your permissions are properly set, your staff is able to retrieve full fee schedules and allowed amounts for specific sets of codes.

**Reimbursement Methodology**

The following details the methodologies used to develop the Schedule of Allowed Benefits:

- Cost-of-living increase.
- Recognition of differences in economy and cost-of-care within the service area.
- Verification of new allowances using dental claims data.
- Review of billed charge data obtained from a current national survey of dental allowances to supplement and confirm local charge information.

**Indemnity Other Party Liability (OPL) Coordination of Benefits**

Coordination of benefits (COB) is a cost-containment provision included in most group and member contracts and is designed to avoid duplicate payment for covered services. COB is applied whenever a member is covered under more than one health insurance plan.

When a member has more than one insurance carrier, the provider's office determines primary and secondary liability. Guidelines for determining primary and secondary liability in specific instances are listed below:

- Member is covered on two different policies and one has no COB provision: When a policy or coverage does not include a COB provision in its contract, it is always primary under any and all circumstances.
- Member is covered under his or her own policy and a spouse's policy and there is a COB provision in both policies: The member's own insurance is primary and the spouse's coverage is secondary. This rule applies even if the member's employment is part-time and the spouse's employment is full-time.
- Eligible dependent children whose mother and father live in the same household and there is COB provision in both policies: When both parents carry health insurance, the insurance carriers will base primary liability on either the birthday rule* or the gender rule**.
- Eligible dependent children whose mother and father are divorced and there is a COB provision in both policies: When parents are divorced, the final
Administrative Functions

- The divorce decree determines which parent's coverage will be primary payer.
- If primary/secondary insurance liability is not addressed in the divorce decree, generally the custodial parent's insurance is considered primary.
- Member is policyholder on two different policies with COB provisions: Coverage from full-time employment is primary to coverage associated with part-time employment. If the member is employed full-time at both jobs or part-time at both jobs, the policy with the earliest effective date is primary.

*The Birthday Rule—We implement this rule, unless
an employer requests otherwise. The carrier whose
parent's birthday is closest to January 1st in the
same calendar year is primary. (Example: A mother’s
birthday is April 29th and the father’s birthday is June 3rd. The mother’s insurance plan would be primary).

**The Gender Rule—The gender rule requires that the
father's coverage is primary. Few carriers practice this
rule. In the event that one carrier uses the birthday
rule and the other carrier uses the gender rule, the
gender rule prevails.

Primary Carrier: CareFirst Traditional and
Preferred Dental Products
Benefits are provided as stipulated in the member's contract. Benefits are provided as stipulated in the member's contract. The member may be billed for any deductible, coinsurance, non-covered services, or services for which benefits have been exhausted as indicated on Notice of Payment (NOP). These charges may then be submitted by the member or the provider on the member's behalf to the secondary carrier for consideration.

Secondary Carrier: CareFirst Traditional or
Preferred Dental Products
When CareFirst is the secondary carrier, there are three different methods for calculating our payment (Regular, Aggregate or Modified Aggregate, as described below), depending on the member’s contract.

Regular Method
The regular provision in a member's contract considers the amount paid by the primary carrier and our Allowed Benefit (AB). If the amount of the primary carrier's payment exceeds or equals the AB, we pay nothing. This method is primarily used by our national accounts, such as the Federal Employee Program (FEP).

The participating provider must accept the AB as payment in full for covered service and cannot balance bill our members. Participating providers can only bill members for claims that are rejected as non-covered or over maximum and for any deductibles and coinsurance not covered by the secondary carrier.

Aggregate Method
The aggregate provision in a member’s contract considers the provider's total charge, the amount paid by the primary carrier and the AB. We subtract the primary carrier’s payment from the total charge and pay the difference, as long as the balance does not exceed the AB.

The provider cannot balance bill the subscriber if the primary carrier and our reimbursement does not equal the total billed charges. The participating provider can only bill for claims that are rejected as non-covered or over maximum and for any deductibles and coinsurance.

Modified Aggregate Method
The modified aggregate provision in a member’s contract considers the primary carrier’s AB, the amount paid by the primary carrier and our AB. We subtract the primary carrier’s payment from the higher of the two ABs and pay the difference, as long as the balance does not exceed our AB.

The participating provider cannot balance bill the subscriber if the primary carrier and our reimbursement does not equal the total billed charges. The participating provider can only bill for claims that are rejected as non-covered or over maximum and for any deductibles and coinsurance.
Primary Commercial Carrier Rejected Claims
If the primary carrier appropriately denies benefits for rendered services, we automatically become the primary carrier for covered services.

COB Provision
Most member contracts feature a Front End COB provision, which requires the provider to determine the primary carrier, file the claim with that carrier and submit a claim to the secondary carrier along with a copy of the primary carrier’s explanation of benefits.

If we receive your claim without the other insurance information section completed and/or an EOB from the primary carrier (if appropriate), it may be returned or rejected.

Workers’ Compensation
Dental benefits programs administered by CareFirst exclude benefits for services or supplies to the extent that the participant obtained or could have obtained benefits under a Workers’ Compensation Act or a similar law. Affected claims should only be filed if workers’ compensation benefits have been denied or exhausted. In the event that benefits are inadvertently or mistakenly paid despite this exclusion, we will exercise the right to recover its payments.

A participating provider cannot balance bill the member or CareFirst for any amount not covered under Workers’ Compensation. Regulations applicable to Workers’ Compensation require the provider to accept reimbursement as payment in full.

Claims filed indicating that the member has sustained or suspects injuries or illnesses arising out of or in the course of employment will be rejected.

Exceptions: The Federal Employee Program requires that payment be made at the time the claim is submitted. If the claim is later paid by Workers’ Compensation, money originally paid will be recouped. If Workers’ Compensation determines that the injury or illness is not compensable, the claim will be processed, regardless of timely filing guidelines.

Subrogation
Subrogation refers to our right to recover payments made on behalf of a participant whose illness, condition or injury was caused by the negligence or wrong-doing of another party. Such action will not affect the submission and processing of claims, and all provisions of the participating provider agreement apply. Subrogation provisions are included in many group and member contracts.

We will process claims and make payments to the participating provider for covered services. When settlement is made by the liable carrier(s), we will recover its payments from the party receiving settlement. At that time, the provider is no longer bound by the terms of the participating agreement. The provider can bill the subscriber up to the total charges, if the subscriber is held harmless and the amount awarded in settlement or by the court is less than the total charge.

If the court ruling or settlement specifies that the losses are for other than medical care (for example, wages, loss of consortium, sorrow, etc.), we may be unable to recoup its entire medical payment and may need to negotiate a settlement. In these instances, the participating provider must accept the Allowed Benefit (AB) as payment in full and cannot balance bill the subscriber. If you receive payments from multiple carriers in excess of billed amounts, contact the appropriate Provider Service area to determine proper distribution of excess payment.

Personal Injury Protection (PIP)
If a member’s contract includes a PIP provision, we will offset or reduce its benefit payments for those medical expenses paid or payable under the PIP provision of the automobile insurance.

Participating providers are required to submit claims on the member’s behalf to comply with the participating agreement and to meet timely filing guidelines, established by the subscriber’s contract. We will reimburse for covered services exceeding the PIP protection. If settlement is subsequently made, we will recover payments from the receiving party.
If we are able to pursue recoupment from the receiving party, the provider can bill the subscriber up to the total charges. If we are unable to recoup its total medical payments and negotiate a settlement, the participating provider must accept the Allowed Benefit (AB) as payment in full and cannot balance bill the subscriber.

DHMO Coordination of Benefits (COB)
When coordinating between an indemnity and a capitation dental plan, the following rules apply:

- When the capitation plan is primary, the capitation copayments to the treating dentist remain the capitation plan’s usual care. The indemnity plan should pay benefits for the patient’s copayment up to the indemnity plan’s allowable benefit.
- When the indemnity plan is primary, and treatment is received from a participating capitation provider, the indemnity plan should pay its allowable benefit. The capitation payments to the dentist are the secondary coverage since they constitute care up to the capitation plan’s allowable amount.

**NOTE:** DHMO providers can only bill the secondary carrier the member’s copayments.

When coordinating benefits between two Capitation Plans, the following rules apply:

**Primary General Dentist (PGD)**
- For a case in which the PGD participates with both of the capitation plans, the patient should be charged in accordance with the lesser of the two copayment schedules. This rule applies regardless whether the two capitation plans are administered by the same managed care company or by two different managed care companies (see Example 1).
- If the PGD only participates with one of the capitation plans, the PGD has no choice but to charge in accordance with the capitation plan in which he/she participates.

**Specialist**
For a case in which the specialist participates with both of the capitation plans and both of the capitation plans are administered by the same managed care company, the patient should be charged in accordance with the lesser of the two copayment schedules and the Specialist should submit a claim for additional payment (if applicable) in accordance with the guidelines set forth by the capitation plan.

For a case in which the specialist participates with both of the capitation plans and the capitation plans are NOT administered by the same managed care company, the patient should be charged in accordance with the plan that has been determined as the primary plan. The specialist should submit a claim for additional payment (if applicable) in accordance with the guidelines set forth by the primary plan.

When the specialist submits a claim for additional payment (if applicable) to the secondary plan, the claim must include an Explanation of Benefits (EOB) from the primary plan. If the secondary plan is a CareFirst DHMO plan, there will not be any additional payment to the specialist if the combined payment from the patient and the primary plan to the specialist is equal to or greater than the amount guaranteed to the specialist by the DHMO.

**Example 1**
**Provider is a PGD**

<table>
<thead>
<tr>
<th>Member copayment under first capitated plan:</th>
<th>$350</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member copayment under second capitated plan:</td>
<td>$300</td>
</tr>
</tbody>
</table>

When coordinating benefits between a capitated plan and an indemnity plan (Traditional or PPO) where the capitated plan is primary, the following rules apply:

- The PGD should submit the patient copayment as specified by the capitation plan to the indemnity plan. The patient is responsible for paying the difference between the amounts reimbursed by the indemnity plan and his/her copayment (see Example 2).
Administrative Functions

- The Specialist should submit the patient copayment as specified by the capitation plan to the indemnity plan. The patient is responsible for paying the difference between the amount reimbursed by the indemnity plan and the copayment. The Specialist should then submit a claim for additional payment (if applicable) to the capitated plan in accordance with his/her contract (see Example 3).

Example 2

**Provider is a PGD**

| Member copayment under capitated plan: | $350 |
| Indemnity plan pays: | - $200 |
| Balance: | $150 |

The PGD should submit the patient copayment as specified by the capitation plan ($350) to the indemnity plan. The patient is responsible for paying the difference between the amount reimbursed by the indemnity plan ($200) and the copayment. In this example, the patient is responsible for a $150 copayment.

Example 3

**Provider is a Specialist**

| Member copayment under capitated plan: | $300 |
| Indemnity plan pays: | - $150 |
| Balance: | $150 |
| Specialist’s guarantee with DHMO: | $350 |

The Specialist should submit the patient copayment as specified by the capitation plan ($300) to the indemnity plan. The patient is responsible for paying the difference between the amount reimbursed by the indemnity plan ($150) and the copayment. In this example, the patient is responsible for a $150 copayment.

Orthodontia

CareFirst does not coordinate coverage for orthodontia. When members have dual dental coverage whereby both plans include orthodontic benefits, CareFirst will process orthodontic claims under both plans simultaneously; there is no primary or secondary carrier in cases of orthodontia under CareFirst policies.

**Primary Carrier ACA embedded Pediatric Dental**

The pediatric dental orthodontic benefit requires pre-authorization for medical necessity before any treatment begins. However, providers may assess the patient prior to submitting a pre-treatment estimate (PTE). If the provider’s assessment of the case results in a low score, there is no requirement to submit the case for review.

In cases where dual orthodontic coverage exists between a standalone option and a medical plan which includes pediatric dental (ACA embedded pediatric dental), the provider should determine if the patient’s orthodontia is medically necessary. When claims are submitted in these situations, CareFirst will process under both plans simultaneously. It is important to note that if the treatment does commence before authorization is received from CareFirst, no benefit will be allowed under the embedded ACA pediatric dental plan. Additionally, cases which have been denied through the Dental Director authorization process will also deny under the embedded ACA pediatric dental plan.
Dental Claims Submission

This manual provides information for CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., and The Dental Network (collectively CareFirst) Dental providers.

Per the terms of the Participating Agreement, all providers are required to adhere to all policies and procedures contained in this manual, as applicable. If we make any administrative or procedural changes, we will update the information in this manual and notify you through email and BluImpressions, our online Dental provider newsletter.

Specific requirements of a member’s Dental benefits vary and may differ from the general procedures outlined in this manual. If you have questions regarding a member’s eligibility, benefits, or claims status information, we encourage you to use one of our self-service channels CareFirst Direct or CareFirst on Call. Through these channels, simple questions can be answered quickly.

Submission Guidelines

Timely Filing of Claims
Dental claims must be submitted within 365 days after the date of service. A member cannot be billed by a participating provider for failure to submit a claim to CareFirst within the 365 day timeframe.

Claims Filing
CareFirst strongly encourages providers to submit claims, pre-treatment estimates, and required attachments electronically. CareFirst’s dental payer code is 00580. CareFirst only requires supporting documentation for certain procedures. These documents can be submitted via National Electronic Attachment (NEA). Please include the NEA document number in the Remarks section on the ADA claim form. Secondary Coordination of Benefits (COB) should not be submitted electronically.

CareFirst has enhanced its electronic claims submission for dental providers, thereby simplifying the method for processing claims and sending payments to dentists.

New electronic capabilities include:

- Electric Funds Transfer (EFT) allows providers to receive payments electronically. A clearinghouse manages provider enrollment and validation date.
- Electronic Remittance Advice (ERA) is equivalent to the Notice of Payment. Some clearinghouses auto-post the ERA and EFT to the patient’s account using the providers Practice Management System.

Visit www.carefirst.com/dentaledi to learn more about electronic claims submission.

Providers without electronic capabilities may submit claims and supporting documentation to the appropriate processing area. See Dental Claims and Service Reference Guide.
Dental Claims Submission

Dental Procedures and Nomenclature
Use the most current edition of the Current Dental Terminology (CDT), published by the American Dental Association (ADA), to report services for treatment. The CDT manual can be purchased directly from the ADA by calling 800-947-4746 or visiting www.ada.org.

Note: The existence of a procedure code does not guarantee coverage; the benefit is determined based on the member’s contract.

Completing a Claim Form
- Use the most current version and instructions of the American Dental Association (ADA) claim form, available at www.ada.org.
- Report completed services using the procedure codes from the most recent ADA Current Dental Terminology® (CDT) Reference Manual.
- Essential data elements must be completed, including patient name, patient date of birth, valid membership ID number, provider tax identification number, signature of dentist or signature on file, valid CDT® procedure codes, teeth numbers and locations if applicable, and procedure charges.
- Social Security numbers will not be accepted in place of a membership ID number. Claims will be returned if the Social Security number is used as an identification number.
- Providers submitting claims for Regional and DHMO members should submit their claims with their actual office charges by procedure.

Claims received without the essential data elements may be returned to the provider of care for corrections.

Pre-Treatment Estimates (PTE)
- Dental providers and/or members who wish to obtain clinical review for dental treatment prior to services being rendered may request a Pre-Treatment Estimate (PTE). CareFirst strongly encourages providers to submit pre-treatment estimates and required attachments electronically or submit a completed American Dental Association® (ADA) claim form, check the box for “Dentist’s pre-treatment estimate” and leave the date of service blank. Include the following:
  - ADA Current Dental Terminology® (CDT) procedure code(s).
  - Appropriate supporting documentation for the service(s) to be rendered (see Reference Guide for Required Attachments). Providers with electronic capabilities are encouraged to submit attachments via National Electronic Attachment (NEA).
  - Please include the NEA document number in the Remarks section on the ADA claim form. For more information, contact NEA at 800-782-5150 and select option 2.

This PTE process is an optional service limited to procedures which are subject to Utilization Review and listed in the Reference Guide for Required Attachments. The PTE provides a clinical review of a proposed treatment plan and is not a guarantee of payment or a pre-authorization.

In the PTE process, benefits will be considered based on current eligibility and clinical guidelines. Providers will be notified on the Estimate of Eligible Benefits (EEB) form indicating approval or denial. Upon completion of treatment, the EEB form should be used to request reimbursement by completing the date of service, signing, and submitting the EEB to the appropriate claim submission address indicated on the form. Resubmission of supporting documentation is not necessary when submitting for reimbursement. Payment will be considered based on the following conditions:
- PTE was issued less than 180 days prior to the date service was completed.
- Member was eligible on the date service was completed.
- Frequency and annual maximums have not been exceeded.
- Service must be a covered benefit at the time the service was rendered.
- Services rendered are consistent with those indicated on the PTE.
Dental Claims Submission

Note: If pre-treatment approval was granted on the EEB form, do not submit a claim form for completed services. Claims received for services that have been approved will automatically generate a request for supporting documentation.

Providers and/or members who choose not to request a pre-treatment estimate (PTE) must continue to submit claims with the required attachments (radiographs, periodontal charting, etc.) for services requiring clinical documentation.

DHMO Claims
Claims are not required of network general dentists as providers are reimbursed capitation and collect copayments from the member. However, providers may be reimbursed a supplemental payment for certain plans/procedures as indicated on the Member Copayment Schedule. Providers are required to submit the most current version of the ADA® claim form and all essential data elements must be completed.

Specialty providers who may be eligible to receive supplemental payments for specific procedures will be paid upon receipt of a completed claim form.

Claims may also be filed electronically through SecureTrack Dental (formerly AnsLink). Call SecureTrack Dental at 877-466-9656 with questions regarding the electronic process.

Oral Surgery and Accidental Injury
Oral surgical services and services rendered as a result of an accidental injury must be reported using the CMS-1500 claim form and the applicable American Medical Association (AMA) Current Procedural Terminology (CPT) or HCPCS Dental (CDT) procedure code(s). Claims should be submitted to the appropriate medical claims processing area. These claims will be processed under the member's medical coverage instead of their dental coverage.

Dental Reference Guide for Required Attachments
As part of our Utilization Management Program, the submission of supporting documentation for select dental procedures is required. The Dental Reference Guide for Required Attachments lists by category of service, the procedure codes and the specific documentation required for submission with the claim.

Note: The requirements for attachments and documentation apply to all procedure codes within the range noted.

ACA Pediatric Orthodontia
The pediatric dental orthodontic benefit requires pre-authorization for medical necessity before any treatment begins. Diagnostic records and the examination do not require a pre-treatment estimate (PTE). If the treatment does commence before authorization is received from CareFirst, no benefit will be allowed.

Orthodontic benefit provisions are slightly different in the ACA dental contracts for Maryland, the District of Columbia, and Virginia.

- Maryland and the District of Columbia use the Handicapping Labiolingual Index (HLD)
- Virginia requires the Salzmann Deviation Index

Providers may assess the patient prior to submitting a PTE. If the provider’s assessment of the case results in a low score, there is no requirement to submit the case for review. If the parent insists or the score is close to passing, CareFirst recommends submitting the case for review.

Other Requirements
The following describes circumstances under which the identified attachment is required for submission with the claim:

- A referral or consultant treatment plan may be required for support of specialty services.
- An explanation of benefits (EOB) statement from a primary payer to CareFirst, if CareFirst is secondary.
- A description of the procedure or service, which may include the dental record, if a procedure
Dental Claims Submission

or service has no corresponding Current Dental Terminology (CDT) code.

- Anesthesia records documenting the time spent on the service.
- Appeal or Grievance: Submit a letter describing the reason for the appeal or grievance and the justification or rationale including supporting clinical notes or dental records (i.e. radiographs, treatment plans or office notes, etc.).
- Information related to a retrospective review and/or an audit, if a pattern of fraud, improper billing or coding is demonstrated.
- Itemized bills
- Dental models
- Radiographs
- Photographs
- Diagnostic test results

When enclosing the appropriate attachments with the claim form, please remember to properly label the attachment with the patient’s name, date, provider name and address, and ensure the radiographs are of diagnostic quality.

Dental offices may also electronically transmit radiographs and/or other supporting documentation to CareFirst through National Electronic Attachment (NEA). Please include the NEA document number in the Remarks section on the ADA claim form. For additional information or to register with NEA, please call NEA at 800-782-5150 and select Option #2.

Inquiries and Appeals

Claim Inquiry

An inquiry is a request for CareFirst to explain why a claim was paid a certain way or why it was rejected. It is an informal request for information and can normally be handled by calling the appropriate provider service area. Inquiries include: amount paid questions, coverage/eligibility questions, deductible/limitation questions, timely filing rejections, and claims resubmitted with required documentation.

Claim Appeals

When CareFirst processes a claim and rejects it due to medical necessity or an adverse decision, providers may appeal the rejection in writing within six months or 180 days (whichever is longer) from the denial notification date.

An appeal is a request in writing to CareFirst for reconsideration of a claim previously rejected. Appeals include: cosmetic rejections, experimental/investigational rejections, and medical necessity rejections.

A member, the member’s authorized representative, or the dentist acting on behalf of the member, has the right to appeal the denial of a claim within 180 days from the date of notification of the denial or benefit determination though the internal review process.

A letter describing the reason(s) for the appeal and the clinical justification/rationale must include the following information:

- Patient name and membership identification number
- Claim number to be reviewed
- Dates of service
- Copy of original claim or Explanation of Benefits (EOB) denial information
- Supporting clinical notes or dental records
- CareFirst may require additional information from the provider

Appeals must be submitted in writing to the appropriate Provider Service Correspondence Department indicating the appeal reason and clearly stating that the request is an appeal.

The appeal will be reviewed by a dentist not involved in the initial denial. All appeal decisions are answered in writing.

Providers should first use the CareFirst internal appeals process before further complaints are made.
Refunding Erroneous Payments

If an overpayment from CareFirst is discovered, the provider should not automatically return the check. This causes a delay in the payment, and the initial check must be voided. Claims will be reprocessed and a new check will be issued. In such a situation, the provider should call the appropriate Provider Service Department and alert the service representative that an adjustment is needed.

The service representative may instruct the provider to refund the amount of overpayment or initiate a voucher deduction. If the amount payable cannot be fully recovered on the next remittance schedule, the balance due is carried forward. Deductions are listed and identified on the final summary page of the remittance. To determine the patient account(s) affected by the deduction, a provider must research prior remittance schedules to determine applicable patient(s) and claim(s), identified by a “CR” in the “Amount Paid” field, that relates to the current deduction.
Dental Claims Processing Policies

This manual provides information for CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., and The Dental Network (collectively CareFirst) Dental providers.

Per the terms of the Participating Agreement, all providers are required to adhere to all policies and procedures contained in this manual, as applicable. If we make any administrative or procedural changes, we will update the information in this manual and notify you through email and BlueImpressions, our online Dental provider newsletter.

Specific requirements of a member’s Dental benefits vary and may differ from the general procedures outlined in this manual. If you have questions regarding a member’s eligibility, benefits, or claims status information, we encourage you to use one of our self-service channels CareFirst Direct or CareFirst on Call. Through these channels, simple questions can be answered quickly.

Edits, Limitations and Billing Guidelines

To process claims accurately and consistently, CareFirst and CareFirst BlueChoice developed Dental Clinical and Policy Guidelines based on current community standards of dental care and are derived through consultation with the ADA® Dental Practice Parameters, dental practices, academic communities and current scientific literature.

The dental policy guidelines are supported by a system designed to adjudicate claims efficiently and accurately based on the member’s contract. These edits use the most cost-effective, clinically appropriate claim reimbursement, based on clinical standards and contractual limitations. (See Dental Clinical Criteria.)

Mutually Exclusive Edits

This is defined as the billing for two or more procedures that, by dental care standards, would not usually be billed for the same patient on the same date of service.

Rebundling Edits

Unbundling occurs when two or more procedures are used to describe a service for which a single, more comprehensive procedure exists that more accurately describes the complete service performed. Unbundled procedures will be rebundled to the correct CDT procedure.

Incidental to/Included in/Integral part of

These terms are defined as procedures carried out at the same time as a primary procedure that are clinically integral to the performance of the primary procedure. Additional reimbursement is not provided for these incidental procedures, as they are included in the allowance for the primary procedure.
Common Limitations and Exclusions

Member contracts include limitations and exclusions, which may vary, based on regulatory requirements and/or the level of coverage purchased by the employer group. This is for informational purposes only.

Below are the most common limitations used in the administration of dental care, and may be combined with other policies and guidelines to ensure cost effectiveness and acceptable community standards of care. Use one of our self service options to verify specific benefit coverage.

General Criteria

Procedures should be performed based on dental necessity and as appropriate in the diagnosis, treatment and care of the member’s condition. Treatment rendered for cosmetic reasons, member convenience or services that do not meet standards of care are not eligible for benefits.

General criteria for members with Indemnity contracts are:

- If there is an alternative dental procedure(s) that meets generally accepted standards of professional dental care for a covered member's condition, the benefit will be provided based upon the lowest cost alternative.
- CareFirst will provide benefits for covered services for a course of treatment up to 90 days after the date a member's coverage terminates, if the treatment:
  - begins before the termination date of the member’s coverage
  - requires two or more visits to the dentist’s office on separate days (this provision does not apply to orthodontic services)

Diagnostic/Preventive Services

The following benefits are generally limited to twice per benefit plan year:

- oral exams (comprehensive oral evaluations are limited to one in a three year period per provider)
- routine prophylaxis
- bitewing radiographs (up to two bitewing procedures/benefit plan year)
- topical fluoride (age limit* applies)

The following benefits are limited to once per 36 months:

- one set of full mouth radiographs OR one panoramic film and one set of bitewing radiographs, in addition to those mentioned above
- one cephalometric radiograph
- sealants on permanent molars, one per tooth (age limit applies)*

The following benefits are limited to once per five years:

- space maintainers for prematurely lost cuspid to posterior deciduous teeth

Restorative Services

The following benefits are generally limited to once per twelve 12 months:

- silver amalgam and composite restorations, one restoration per surface

The following benefits are limited to once per five years:

- dentures, full and/or partials
- fixed bridges, including crowns, inlays and onlays used as abutments for or as a unit of the bridge
- crowns, inlays, onlays
- stainless steel crowns (age limit applies)*

Note: Specific requirements of a member's Dental benefits vary and may differ from the general procedures outlined in this manual. If you have questions regarding a member's eligibility, benefits, or claims status information, we encourage you to use one of our self-service channels CareFirst Direct or CareFirst on Call.

*Age limit – Benefits are provided until the end of the year in which the member turns 19.
The benefit for regular denture adjustment and relining is limited to once per 36 months, but not within six months of the date of initial placement. Please note the following benefit limitations for immediate denture adjustment and relining:

- initial adjustment/relining, three months after placement
- second adjustment/relining, within the first year
- third adjustment/relining, three years thereafter

The following benefits are limited to once per 12 months:

- recementation of crowns, inlays and/or bridges
- repair of prosthetic appliances per specific area of the appliance

The following services are contract exclusions:

- replacement of a denture, bridge or crown as a result of loss or theft
- replacement of an existing denture, bridge or crown that is satisfactory or that could be repaired
- replacement of dentures, a bridge or a crown which were paid partially or fully under the terms of the policy and five years have not lapsed from the date of placement/replacement

**Endodontic Services**

The following contractual limitations generally apply:

- pulpotomy is limited to deciduous teeth
- root canal therapy is limited to permanent teeth
- retreatment of a root canal is limited to one per tooth per lifetime

**Periodontal Services**

The following benefits are generally limited to a full mouth treatment once per 24 months:

- periodontal scaling and root planing
- gingival curettage

The following benefits are limited to once per five years:

- osseous surgery, including flap entry and closure; one full mouth treatment
- gingivectomy; one full mouth treatment
- limited or complete occlusal adjustments in connection with periodontal treatment
- mucogingival surgery limited to grafts and plastic procedures, one treatment per site

**Oral Surgical Services**

Some oral surgical procedures may have a benefit under a member's medical policy, including:

- services related to the treatment of temporomandibular disorder (TMD)
- treatment of fractures, simple or compound
- orthognathic surgery
- accidental injury

The following benefits are available based on the dental policies outlined below:

- both the extraction of a tooth and surgical removal of a cyst only if the cyst is > 1.25 cm. If the cyst measures < 0.5 cm, a benefit is provided for the extraction only; the cyst is considered inclusive
- alveoloplasty, only if three or more teeth in a quadrant were extracted
- frenuloplasty and soft tissue graft performed on the same day. Please note: the benefit is provided for the graft only and the frenuloplasty is considered inclusive

Endodontic procedures include:

- oroantral fistula closure
- tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth and/or alveolus
- tooth transplantation
- surgical repositioning of teeth
- vestibuloplasty, covered under ACA plans only
Anesthesia Services
A benefit for general anesthesia and intravenous sedation is provided if:
- required for oral surgery and,
- administered by a dentist who has a permit to administer conscious sedation or general anesthesia.

The following oral surgical services are eligible for general anesthesia and/or intravenous sedation if the oral surgery is covered under a member’s policy:
- apicoectomy
- surgical extractions (two or more) and soft tissue, partial/completely bony
- root resection
- hemisection
- surgical removal of residual tooth roots (cutting procedures)
- osseous surgery
- oroantral fistula closure
- bone replacement graft
- tooth reimplantation
- pedicle soft tissue graft
- free soft tissue graft
- surgical exposure of impacted or unerupted tooth
- alveoloplasty
- vestibuloplasty
- removal of odontogenic/nonodontogenic cyst or tumor
- removal of exostosis
- incision and drainage of abscess – intraoral/extraoral soft tissue
- excision of hyperplastic tissue

Benefits for local anesthesia are considered inclusive to the primary procedure(s) performed and a separate benefit is not provided.

Orthodontic Services
A benefit for orthodontic treatment is provided to members that meet the following criteria:
- orthodontic coverage is provided in the member’s contract and,
- the member is eligible to receive orthodontic benefit (for example, a member has orthodontic coverage in his contract, but only his dependent can take advantage of the benefit) and,
- the orthodontic treatment is to reduce or eliminate an existing malocclusion.

Initial Consultation
To facilitate a complete and comprehensive orthodontic treatment plan, the orthodontist documents a member's medical/dental history, dental occlusion, overall dental condition, the relationship between the teeth and skeletal structure. Use ADA Consultation Procedure Code D9310.

Diagnostic Records
Pre-treatment records are important tools for orthodontists to make an accurate diagnosis and develop the treatment plan. The records include study models, diagnostic photographs, cephalometric and panoramic films. Use ADA Procedure Codes:
- Panoramic Radiograph – D0330
- Cephalometric Radiograph – D0340
- Diagnostic Casts – D0470
- Oral/Facial Images – D0350/D0351

Active Comprehensive Orthodontic Treatment
Active orthodontic treatment begins with the insertion of the appliance. (The banding date.) The comprehensive treatment procedure codes include the placement of the appliance, adjustments/follow-up (monthly visits), the removal of the appliance, construction of the retainer and any other follow-up treatment to maintain the achieved anatomical, functional and aesthetic results and/or stabilize the dentition after removal of the appliance.
The dentist should select the comprehensive ADA Procedure Code that is most appropriate to the patient’s current stage of dentofacial development:

- D8070 – Comprehensive orthodontic treatment of the transitional dentition
- D8080 – Comprehensive orthodontic treatment of the adolescent dentition
- D8090 – Comprehensive orthodontic treatment of the adult dentition

**Benefit Guidelines for Traditional and Preferred Dental**

For members covered under the Traditional and Preferred Dental plans, the benefit for the orthodontic treatment is provided in the quarterly or monthly installments, based on the group’s specifications and determined on the anticipated length of treatment. When submitting the initial claim for orthodontic treatment, include the following information:

- banding date
- length of treatment (in months)
- total charge for the treatment

Dentists will submit one claim for the entire orthodontic course of treatment. An initial payment for comprehensive treatment is made upon banding and consists of the lesser of:

- 25 percent of the Allowed Benefit or 25 percent of the member’s orthodontic lifetime maximum

Payments of the remaining allowance will be spread throughout the remaining months of treatment. We will automatically make quarterly or monthly payments based on the existing treatment plan for ACA ortho guidelines. For CFA patients, contact CFA customer service.

The benefit will continue to be paid until treatment is completed if the following conditions exist:

- the policy remains active
- the member remains covered under the policy
- the member has not reached the age of ineligibility as defined in the contract
- the member’s lifetime maximum has not been exhausted

**Billing Guidelines for Individual Select Preferred (ISP)**

For members covered under the ISP plan, claims for the initial consultation and diagnostic records should be submitted to CareFirst for reimbursement. Claims should not be submitted for the comprehensive treatment. These services can be billed directly to the member at the time of banding.

**Billing Guidelines for DHMO**

For members covered under the Dental HMO, providers should charge the member the appropriate copayment for services based on the appropriate Member Copayment Schedule. Specialists should submit one claim for the entire orthodontic course of treatment and one payment will be made for the difference between the member’s copayment and the provider’s Orthodontic Guarantee.

**Billing Guidelines for Patients with Dual Orthodontic Coverage**

Health Insurance Exchanges in Maryland, the District of Columbia, and Virginia established under the Affordable Care Act (ACA) enroll individuals and families who purchase health insurance plans offered by CareFirst and other carriers. CareFirst’s medical plans offered in the individual and small group markets (both on and off of the Exchange) have the mandated 10 Essential Health Benefits (EHB), which include a pediatric dental benefit. They do not include an adult dental EHB; dental coverage for adults age 20 and older must be purchased through a separate dental plan.

**Patient Qualifies for Dual Orthodontic Coverage**

Once pediatric orthodontic medical necessity is determined using our Salzmann or HLD form, providers should submit a pre-treatment estimate (PTE) for review by the office of the CareFirst Dental Director. If the orthodontic treatment is approved, providers will receive an estimate of eligible benefits (EEB) detailing the approval. It is important to note that orthodontic cases started without an approval from CareFirst will not be given a benefit, regardless of the medical necessity. Providers should submit the approval EEB, along with the banding date,
length of treatment, and total charge, to CareFirst for reimbursement.

**Patient Does Not Qualify for Dual Orthodontic Coverage**

If the provider’s assessment of an orthodontic case results in a low score, there is no requirement that the case must be submitted for review. In these cases, providers should expect to receive two Notices of Payment (NOPs): one reflecting a denial under the patient’s pediatric dental plan, and the second showing that the treatment has been processed.

**Orthodontic Lifetime Maximum**

Orthodontic benefits are based on the member’s contract. The orthodontic lifetime maximum amount varies by account. Use one of our self service options to verify specific benefit coverage.

Members seeking treatment from a Participating orthodontist are responsible for the coinsurance percentage associated with the treatment; the amount of member liability should not exceed the CareFirst Allowed Benefit. Participating providers are encouraged to review their CareFirst Fee Schedule to determine the appropriate allowance for the procedure code. The allowance for the comprehensive treatment will be determined at the time the appliance is placed; any increase in allowances that may occur during the course of treatment will not apply to orthodontic cases in progress.

**Orthodontic Treatment in Progress**

Members enrolled after the placement of the appliance may be eligible to receive orthodontic benefits for the treatment in progress. Use one of our self service options to verify specific benefit coverage.

Providers should submit the total charge, total length of treatment and original banding date. CareFirst will prorate the treatment plan and consider a benefit based on the cost of the remaining treatment. All expenses incurred prior to the effective date of the contract are not eligible for reimbursement and are considered to be the member’s responsibility.

**Members Transferring from Another Orthodontist**

New orthodontists must submit a claim indicating the anticipated number of months in the treatment plan and include the charge for the treatment and banding date, if appropriate.

A payment schedule will follow the monthly or quarterly installments; however, the initial allowance of 25 percent will not apply and the benefit will be limited to the remaining lifetime maximum amount.

**Traditional and Preferred Dental Guidelines for Dental Implants**

The dental implant policy applies only to members covered under the Standard Traditional and Preferred dental products. Some contracts may vary and, therefore, exclude dental implants or may limit coverage of dental implants to the replacement of one missing tooth as an Alternate Benefit in lieu of a 3-unit bridge.

**Clinical Guidelines**

- All dental implants and related services are subject to review by the Dental Director.
- A benefit is subject to medical necessity. The treatment must meet the criteria and be clinically appropriate based on accepted standards of dental care.
- Dental Implants are not recommended nor will a benefit be provided for young patients who have potential for future growth and development of their oral structures.
- A benefit applies only to the replacement of natural missing teeth.
- An implant must be necessary to restore the dental arch to form and function.
- A benefit may be considered only for teeth #2 – #15 and #18 – #31.
- An alternate benefit may be considered if there is a more conservative, less expensive treatment available that meets the standard of care.
- A benefit will not be provided to replace a supernumerary tooth.
A benefit will not be provided to replace a tooth or teeth in space(s) not created by a missing natural tooth or teeth or created by a supernumerary tooth.

A benefit may be considered only when the implant permits replacement of a functional tooth.

Provider Guidelines

Providers are encouraged to file a request for a pre-treatment estimate. CareFirst strongly encourages providers to submit pre-treatment estimates and required attachments electronically or submit a current ADA claim form, check the box for “Dentist's pre-treatment estimate” and leave the date of service blank.

The appropriate supporting documentation must be submitted with the pre-treatment estimate or claim. (See the Dental Reference Guide for Required Attachments). Radiographs must be of diagnostic quality and properly labeled with the patient’s name, dentist’s name and address. Providers may also electronically transmit the supporting documentation via National Electronic Attachment, Inc. (NEA). Please include the NEA document number in the Remarks section on the ADA claim form. For more information, contact NEA at 800-782-5150 and select option #2.

Financial Responsibility

Implants used to replace missing teeth can require considerable out of pocket costs for CareFirst members. Dentists must discuss financial arrangements with the member seeking any major services. Providers may request a pre-treatment estimate, along with the supporting required documents, for clinical review.

Implant Quality Assurance

Adherence to the Parameter on Placement and Management of the Dental Implant (American Academy of Periodontology) or Parameters of Care (American Association of Maxillofacial Surgeons – ParCare 07) is expected for all implants for which a benefit has been provided by CareFirst. Failure of an implant due to inadequate planning, placement and management as defined in the Parameter, will result in a Quality Improvement investigation.

Member Contractual Limitations and Exclusions for Standard Traditional and Preferred Dental Members

All existing contractual provisions, limitations and exclusions apply. Specifically:

- Major restorative – services limited to once per 60 months (five years) or as stated in the member’s contract.
- Replacement of an existing denture or bridge that is determined by CareFirst to be satisfactory or repairable.
- Implant services performed for elective and/or cosmetic reasons will not be covered.
- Benefit is subject to member’s annual contract maximums.
Membership and Product Information

This manual provides information for CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., and The Dental Network (collectively CareFirst) Dental providers.

Per the terms of the Participating Agreement, all providers are required to adhere to all policies and procedures contained in this manual, as applicable. If we make any administrative or procedural changes, we will update the information in this manual and notify you through email and BlueImpressions, our online Dental provider newsletter.

Specific requirements of a member’s Dental benefits vary and may differ from the general procedures outlined in this manual. If you have questions regarding a member’s eligibility, benefits, or claims status information, we encourage you to use one of our self-service channels CareFirst Direct or CareFirst on Call. Through these channels, simple questions can be answered quickly.

Membership

Member’s Rights and Responsibilities

Members have a right to:

- be treated with respect and recognition of their dignity and right to privacy
- receive information about the Health Plan, its services, its practitioners and providers, and members rights and responsibilities
- participate with practitioners in making decisions regarding their health care
- discuss appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- make recommendations regarding the organization’s members’ rights and responsibilities policies
- voice complaints or appeals about their plan or the care provided
- provide, to the extent possible, information that the Health Plan and its practitioners and providers need in order to care for them
- understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible
- follow the plans and instructions for care that they have agreed on with their practitioners
- pay member copayments or coinsurance at the time of service
- be on time for appointments and to notify practitioners/providers when an appointment must be canceled
Membership and Product Information

Dental Products

CareFirst Traditional Dental
Traditional Dental members may seek treatment from any Participating Provider in the network. Reimbursement is based on 100 percent of the Traditional Allowed Benefit (AB) with applicable deductibles and co-insurance. Members seeking treatment from non-participating providers receive 100 percent of the AB for covered services, subject to deductibles, co-insurance and balance billing.

CareFirst Preferred Dental
Preferred Dental Members may seek treatment from any Preferred Dental Provider in the network. Reimbursement is based at 100 percent of the Preferred Allowed Benefit with applicable deductibles and coinsurance. Members seeking treatment from a participating (not a preferred provider) may receive benefits at a reduced rate and are subject to billing up to the Traditional Allowed Benefit. Members seeking treatment from non-participating providers receive benefits at a reduced rate and are subject to deductibles, co-insurance and balance billing.

CareFirst BlueChoice and The Dental Network (DHMO)
DHMO members are required to select a general dentist who participates in their plan as their primary care dentist. If members do not select a primary care dentist, one will be assigned. If a member needs to see a specialist for dental procedures, they should obtain a referral from their primary care dentist to an in-network specialist.

CareFirst BlueChoice Discount Dental Program
Discount Dental is a free discount program offered to all CareFirst BlueChoice Medical HMO members at no additional cost. Members have access to any provider who participates in DHMO Discount Dental Program and can receive discounts on dental services through this program. Because it is a discount program and not a covered benefit, there are no claim forms, referrals or paperwork to complete. Members must show their CareFirst BlueChoice membership card and pay the discounted fee at the time of service to save.

CareFirst Individual Select Preferred (ISP)
The Individual Select Preferred (ISP) is designed to utilize the CareFirst Participating and Preferred Provider Networks. This product offers its enrollees full coverage for Preventive/Diagnostic (Class I) services provided the services are performed by an in-network dentist. Participating Providers are only required to file claims for Class I services. Services in the Class II, III, IV and V categories may be billed directly to the member at the time of service, at the provider’s usual charge.

ACA embedded Pediatric Dental
Health Insurance Exchanges in Maryland, the District of Columbia, and Virginia established under the Affordable Care Act (ACA) enroll individuals and families who purchase health insurance plans offered by CareFirst and other carriers. CareFirst’s medical plans offered in the individual and small group markets (both on and off of the Exchange) have the mandated 10 Essential Health Benefits (EHB), which include a pediatric dental benefit. They do not include an adult dental EHB; dental coverage for adults age 20 and older must be purchased through a separate dental plan.

FEHBP
The FEP Preferred Dental plan is offered to employees of the Federal Government. This coverage is included in the member’s medical plan, and benefits are subject to negotiated, discounted amounts referred to Maximum Allowable Charges (MACs) as payment in full for services listed on FEP’s schedule of benefits. Services not listed under the FEP’s schedule of benefits will be member liability, based on the provider’s charge. Members can choose from the Standard Option plan or the Basic Option plan. FEP eligibility is available on CareFirst Direct.

FEP BlueDental
The Blue Cross Blue Shield Association (BCBSA) has partnered with the GRID Dental Corporation (GDC) to administer FEP BlueDental. FEP BlueDental members will be able to utilize the GRID+ network as an in-network provider source. By participating with CareFirst, providers will now have access to FEP BlueDental members. The member’s card will be identified with FEP BlueDental, along with the claims submission address and customer service number to verify benefits. FEP members enrolled in both medical coverage and the FEP BlueDental plan should always consider their medical coverage primary. Claims for
members who enroll in both the BCBS FEP Service Benefit medical plan and FEP BlueDental should always be sent to the BCBS FEP Service Benefit medical plan first, for primary consideration, and are automatically routed to FEP BlueDental for secondary coverage consideration.

Identifying Product Type by Indicator

All membership ID cards have a dental indicator that tells what type of dental plan covers the member.

- Traditional Dental members are identified by the DT indicator on their ID card
- Preferred Dental members are identified by the DP indicator on their ID card
- Individual Select Preferred Dental members are identified by the DS indicator on their ID card
- DHMO Dental members are identified by the DH indicator on their ID card
- ACA Pediatric Dental members are identified by the PD indicator on their ID card
- GRID or GRID+ Dental members are identified by the GRID or GRID+ indicator on their ID card
- NCAS and CareFirst Administrators (CDA) Dental members are identified by the NCAS or CFA logo in the top left hand corner on their ID card
Membership Identification Card
Quick Reference Guide

Membership identification cards contain important membership and coverage information that help you correctly route your claims. Be sure to verify eligibility using CareFirst Direct or CareFirst on Call prior to rendering care.

Front of Card

The front of the member ID card contains information about the member and some of their member benefits.

1. Member Name
2. Member ID Number
3. Group Number
4. Dental coverage
5. Product type indicator

Back of Card

The back of the member ID card includes product type indicators, as well as instructions and an address for filing claims and sending correspondence.
# Membership Identification Card Quick Reference Guide

## Product Information

<table>
<thead>
<tr>
<th>Product Information</th>
<th>Logos</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHMO</td>
<td><img src="image1.png" alt="BlueChoice" /></td>
</tr>
<tr>
<td>• BlueChoice DHMO</td>
<td></td>
</tr>
<tr>
<td>• The Dental Network DHMO</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discount Dental</th>
<th><img src="image3.png" alt="CareFirst" /></th>
</tr>
</thead>
<tbody>
<tr>
<td>All BlueChoice plan holders have the Discount Dental plan. The DHMO Network is utilized.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Federal Employee Program (FEP)</th>
<th><img src="image4.png" alt="BlueCross BlueShield" /></th>
</tr>
</thead>
<tbody>
<tr>
<td>• FEP Basic Option</td>
<td></td>
</tr>
<tr>
<td>• FEP Standard Option</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FEP BlueDental</th>
<th><img src="image5.png" alt="FEP BlueDental" /></th>
</tr>
</thead>
<tbody>
<tr>
<td>• High Option Benefits</td>
<td></td>
</tr>
<tr>
<td>• Standard Option Benefits</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CareFirst Administrators (CFA)</th>
<th><img src="image6.png" alt="CareFirst" /></th>
</tr>
</thead>
<tbody>
<tr>
<td>These plans may or may not use the CareFirst Traditional or PPO Networks. CareFirst recommends verifying benefits for these members using the toll-free customer service phone number listed on the back of these cards.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NCAS</th>
<th><img src="image7.png" alt="ncas" /></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## National Network Product Information

<table>
<thead>
<tr>
<th>Logo Description</th>
<th>What it Means</th>
<th>What it Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>GRID</td>
<td>The member has PPO coverage benefits available for dental services received from a participating dentist inside the U.S., from a Blues plan.</td>
<td>Participating CareFirst Traditional or PPO Dental providers will be listed in the national Dental GRID and Dental GRID+ directory. The program offers providers access to more patients who hold the Cross and Shield insurance. Participating providers submit claims directly to the member's plan. Providers will also be paid by the member's plan, according to the provider's current CareFirst reimbursement agreement.</td>
</tr>
<tr>
<td>GRID+</td>
<td>The member has Traditional coverage benefits available for dental services received from a participating dentist inside the U.S., from a Blues plan.</td>
<td></td>
</tr>
</tbody>
</table>

---

DENTAL | PROVIDER MANUAL

[![CONTENTS](image8.png)](CONTENTS.html) [LAST VIEWED](LAST VIEWED.html)